

# Evidence to Guide Action:

## Comprehensive tobacco control in Ontario (2016)

Smoke-Free Ontario Scientific Advisory Committee



April 2017

## Public Health Ontario

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### **How to cite this document:**

Smoke-Free Ontario Scientific Advisory Committee, Ontario Agency for Health Protection and Promotion (Public Health Ontario). Evidence to guide action: Comprehensive tobacco control in Ontario (2016). Toronto, ON: Queen's Printer for Ontario; 2017.

ISBN 978-1-4606-9976-8 [PDF]

Public Health Ontario acknowledges the financial support of the Ontario Government.

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The following discussion of the health care sector covers interventions in inpatient and outpatient settings, followed by interventions for health care providers to enhance their capacity in cessation intervention, including electronic record-keeping as an aid.

## Hospital-Based Cessation Interventions

*In Ontario, most hospitals provide at least a brief cessation intervention often with post-discharge referral to ongoing support, and some provide more intensive evidence-based inpatient programs (e.g., the OMSC program and Moving On to Being Free™). Based on the summary of evidence, higher intensity counselling interventions with a minimum of one month post-discharge support, with or without NRT, are effective at increasing smoking cessation. Inpatient interventions have the potential to increase quit attempts since hospitalization provides an opportunity to intervene with smokers who might not otherwise seek smoking cessation interventions. There is an opportunity to continue to expand brief interventions with post-discharge referrals and intensive interventions into all hospitals in Ontario to provide smoking cessation services.*

*SFO-SAC 2016 Scientific Consensus Statement*

## Background

Hospitals are institutions for treating the sick and injured (see the [Glossary](#) for full definition). Since smoking causes many types of health problems,<sup>69</sup> hospitals are a setting where it is possible to reach smokers who are experiencing the negative health effects of smoking and who may be more motivated to quit smoking.<sup>12</sup> Clinical smoking cessation interventions for patients include brief to intensive behavioural interventions and/or pharmacotherapy, with or without continued contact after hospital discharge. Smoke-free policies in hospitals support cessation, and as of 2018, all hospitals will be required to have smoke-free campuses (SFOA Hospitals), which is a contributing factor to the intensity of the interventions delivered.

## The Ontario/Canadian Context

In 2011, the Ontario Tobacco Research Unit (OTRU) in partnership with the former Ministry of Health Promotion and Sport (MHPS) and the Ministry of Health and Long-Term Care (MOHLTC) conducted a web survey of Ontario hospitals to identify the status of hospital-based smoking cessation services, practices and policies.<sup>70</sup> The survey was a first step in a larger collaborative initiative to enhance cessation support to hospital patients with chronic disease.<sup>70</sup> A total of 165 out of 224 (74%) hospital sites in Ontario identified by MOHLTC completed the survey. Key findings from the report included:

- A majority of hospital sites (86%) reported offering cessation services to patients.
- Nicotine replacement therapy (73%), self-help materials (65%) and patient referrals to external sources (50%) were the three most common cessation services provided for inpatients.
- Nurses (89%) and physicians (79%) were the most commonly cited health professionals within the hospital who provided smoking cessation services to patients.

- The most commonly reported policies and practices to support smoking cessation were:
  - Documenting patient smoking status upon admission (79%)
  - Making smoking cessation pharmacotherapies available in the hospital formulary (73%)
  - Having standard methodology to identify smoking status (69%)
  - Having smoking cessation support for hospital staff (62%).<sup>70</sup>

The Ottawa Model for Smoking Cessation (OMSC), developed at the University of Ottawa Heart Institute, uses outreach facilitation (implementation support) and principles of organizational change and knowledge translation to embed and systematize evidence-based tobacco cessation interventions within hospitals and other health care organizations.<sup>71</sup> Once implemented, the model leads to the following five components: systematic identification of patient smoking status, documentation of smoking status on patient record, strategic advice for withdrawal management and quit attempts, offer of pharmacotherapy, and follow-up support for six-months post-discharge.<sup>72</sup> As of 2014, the OMSC has been implemented in 100 hospitals in Canada,<sup>73</sup> and evaluations show that Ontario hospitals reached 14,675 smokers in 2014/2015.<sup>9</sup>

The intensive case-managed smoking cessation intervention, Moving On to Being Free™, developed at Stanford University,<sup>74</sup> has been available for implementation into North Western (NW) Ontario hospitals since 2012. The intervention, which has consistently achieved the highest cessation outcomes in the published literature, involves an initial face-to-face session, followed by seven telephone counselling sessions over the first two months post-discharge, additional sessions as requested and follow-up at three, six and 12 months post-discharge.<sup>12</sup> The outcomes in NW Ontario (not yet published) are identical to the outcomes in the randomized clinical trials, and are among the highest quit rates reported in the literature.

From 2013-15, the MOHLTC provided funding to fourteen hospitals across Ontario to develop and implement an evidence-based smoking cessation intervention that targets inpatients and outpatients with chronic diseases (asthma, cardiovascular disease, COPD, diabetes and lung cancer). The project was known as the Hospital Demonstration Project Initiatives.<sup>9</sup> The 14 demonstration project sites represented a geographic spread across 10 of the 14 Local Health Integration Networks (LHIN) regions and a mix of hospital types (seven community hospitals, one academic ambulatory care hospital, three teaching hospitals, one chronic rehabilitation hospital and two mental health hospitals).<sup>9</sup> There is no evaluation information available at this time.

### Evaluation Highlight

In 2010, an evaluation was conducted using the RE-AIM framework (Reach, Efficacy, Adoption, Implementation and Maintenance) to determine the impact of the OMSC in nine hospitals in the Champlain Local Health Integration Network.<sup>71</sup> The evaluation found that the six-month continuous abstinence rate was significantly higher post-OMSC than pre-OMSC (OR: 1.71, 95% CI: 1.11-2.64).<sup>71</sup> Similar results were found in a larger evaluation that included an additional four hospitals in New Brunswick and three in British Columbia (OR: 1.78, 95% CI: 1.30-2.45).<sup>72</sup> The OMSC has also been shown to be a cost-effective strategy for treating smokers with chronic diseases, such as acute myocardial infarction, unstable angina, heart failure and chronic obstructive pulmonary disease (COPD) (Mullen

2015).<sup>73</sup> A recent before-and-after study, completed in partnership with the Institute for Clinical Evaluative Sciences (ICES), examined the effectiveness of implementation of the OMSC in 14 Ontario hospitals on health and health care outcomes (n=1367 patient smokers).<sup>75</sup> Main findings were:

- 35% of the patients who received the OMSC were smoke-free at six-months, compared to only 20% of the usual care participants
- Within 30 days of discharge, patients who received the OMSC were 50% less likely to be re-admitted to the hospital for any cause, and 30% less likely to visit an emergency department
- Two years after discharge, smokers who received the OMSC were 21% less likely to be re-hospitalized and 9% less likely to visit an emergency department
- Smokers who received the OMSC had a 40% reduction in risk of death over two years.

As of March 2015, OMSC hospital partners more than doubled the number of smokers who receive cessation support each year, from just over 7,000 in 2009-10 to 14,675 in 2014-15.<sup>9</sup> Partners included 75 hospital sites in Ontario, representing 56 hospital organizations.<sup>9</sup> An analysis of a large sample of OMSC participants found that 55.3% of participants were male, and that the average age of participants was 55.7 years.<sup>9</sup>

## Evidence

One Cochrane meta-analysis<sup>12</sup> was retrieved from the pre-appraised literature search. It was appraised as Level I. Most studies in this meta-analysis were conducted in the U.S., with some in Europe, Canada and Australia and one each in Japan and Israel.

### Evidence of Effectiveness

The Cochrane meta-analysis included fifty trials that investigated the effects of various cessation interventions on hospitalized patients.<sup>12</sup> The authors grouped the interventions into four categories based on intervention intensity: single in-hospital contact lasting 15 minutes or less with no post-discharge follow-up support (level 1); one or more in-hospital contacts lasting more than 15 minutes in total with no post-discharge follow-up support (level 2); any in-hospital contact with post-discharge follow-up support for one month or less (level 3); and, any in-hospital contact with post-discharge follow-up support continuing for longer than one month (level 4).<sup>12</sup> The authors found that the most intensive (level 4) significantly increased quit rates (RR: 1.37, 95% CI: 1.27-1.48) one-year after discharge compared to usual care.<sup>12</sup> The less intensive interventions (levels 1-3) were not effective. NRT along with the most intensive intervention significantly increased quit rates (RR: 1.54, 95% CI: 1.34-1.79) compared to the intensive intervention alone.<sup>12</sup> Significant effects were not found for varenicline or bupropion.<sup>12</sup>

### Intervention Characteristics/Implementation Considerations

No information on intervention characteristics and/or implementation considerations was identified from the included literature of this report.

## Specific Populations/Equity Considerations

No information on specific populations and/or equity was identified from the included literature of this report.

## Intervention Summary

### **Evidence Summary - Hospital-based Cessation Interventions- Well supported**

The body of evidence for the effectiveness of smoking cessation interventions in hospital-based cessation interventions included one systematic review appraised as Level I. Highly-intensive behavioural interventions, defined as any in-hospital contact with >one month follow-up post-discharge, with or without NRT, are effective for smoking cessation (at  $\geq$ six months of follow-up). There is no evidence for lower intensity interventions (i.e., no follow-up or follow-up less than one month post-discharge) or for varenicline or bupropion. The interventions in hospital settings examined in the review varied in type and intensity, and were delivered by various health professionals (mostly nurses and counsellors) in staff positions dedicated to cessation and not added to all clinicians' workloads.

### **SFO-SAC 2016 Scientific Consensus Statement - High (Intensify)**

In Ontario, most hospitals provide at least a brief cessation intervention often with post-discharge referral to ongoing support, and some provide more intensive evidence-based inpatient programs (e.g., the OMSC program and Moving On to Being Free™). Based on the summary of evidence, higher intensity counselling interventions with a minimum of one month post-discharge support, with or without NRT, are effective at increasing smoking cessation. Inpatient interventions have the potential to increase quit attempts since hospitalization provides an opportunity to intervene with smokers who might not otherwise seek smoking cessation interventions. There is an opportunity to continue to expand brief interventions with post-discharge referrals and intensive interventions into all hospitals in Ontario to provide smoking cessation services.

The scientific consensus regarding the potential contribution for Ontario is: High (Intensify).

### **Key Message**

Intensive behavioural interventions with or without NRT, which are effective for smoking cessation in hospital-based cessation interventions, are currently in many Ontario hospitals, and should be available in all hospitals. Follow-up is an essential component for success and access to post-discharge NRT would be beneficial.

## Other Health Care Setting Cessation Interventions

*There are programs in Ontario that support other health care setting cessation interventions to provide smoking cessation services. Examples include the TEACH Project and the Registered Nurses' Association of Ontario: Nursing Best Practice Smoking Cessation Initiative. There are also Ontario initiatives that aim to facilitate the delivery of cessation services, including the OMSC, Moving On to Being Free™, and Smoking Treatment for Ontario Patients program (STOP). Based on the summary of evidence, smoking cessation interventions were effective at increasing smoking cessation in all locations (except in emergency departments), regardless of the type of health professional who delivered the intervention. Interventions in other health care settings could reach a number of smokers in Ontario. It is important to ensure that all types of primary health care teams (i.e., solo primary care physicians and physician groups) and private practices (i.e., dentistry) receive support to deliver smoking cessation interventions.*

*SFO-SAC 2016 Scientific Consensus Statement*

### Background

This section includes interventions for people receiving primary care, outpatient surgery, emergency care, dental care and pharmacy services, as well as interventions that focus on improving the capacity of health care professionals as an implementation consideration. Although smoking cessation services are also provided in private homes and residences by health care professionals (e.g., nurses and occupational therapists), evidence on these smoking cessation interventions was not found in the published literature.

### The Ontario/Canadian Context

In Ontario, there are a variety of primary care funding models that ultimately can affect the type and extent to which cessation services are offered. The funding models range from the traditional fee-for-service model for solo practitioners to a variety of more recently-developed group practice models.<sup>76</sup> Group models provide varying levels of support for physicians and nurse practitioners to work in cooperation and use the services of other health care professions.<sup>76</sup> Some of the models support dedicated positions for chronic disease prevention and management care and strongly support the delivery of cessation services, including more intensive interventions, which can be challenging to deliver in solo fee-for-service practices.

Since 2010, there have been various initiatives funded through the MOHLTC SFO Strategy to increase access to cessation support in primary care and other health care settings. Moving On to Being Free™, a derivative of Staying Free, an intensive provider-managed cessation intervention modified for the outpatient setting, is currently in 21 sites in northern Ontario (e.g., Family Health Team clinics, Community Health Centres and mobile units, Aboriginal Health Access Centres, public health units and home visits, and hospital outpatient programs) and has provided interventions to patients in 73 communities, including 36 First Nations communities.<sup>74</sup> The intervention includes web-based software

that guides providers through the intensive cessation intervention using branching algorithms that tailor the intervention to individuals.

In 2011, the Ontario government established the Ontario Pharmacy Smoking Cessation Program, which provides funding to community pharmacists to offer cessation support to Ontario Drug Benefit recipients and some Green Shield Canada plan members, through quit smoking materials and counselling.<sup>77</sup>

Since 2010, the Ottawa model has partnered with a total of 83 primary care organizations that represent more than 160 primary-care sites.<sup>9</sup> Examples of Ontario Primary Care Teams includes Family Health Teams, Community Health Centers and Nurse Practitioner-Lead Clinics.<sup>78</sup>

The Smoking Treatment for Ontario Patients program (STOP), which provides clients with cost-free NRT along with ongoing practitioner training support, has expanded into Family Health Teams, Community Health Centers, Aboriginal Health Access Centers, and Nurse Practitioner-Lead Clinics.<sup>78</sup> In 10 years, STOP has treated 170,000 Ontario smokers or roughly 8.5% of smokers. Current offerings in non-hospital settings treat approximately 25,000 smokers annually (1.25% of smokers). STOP is adopted and implemented in 84% of FHTs, 78% of CHCs, 45% of Community Addiction Agencies, 75% of NPLCs, and 100% of Aboriginal Health Access Centres. In addition, 100% of public health units operationalize the STOP on the Road program and have held 635 cessation workshops across Ontario. Quit rates at three, six and 12 months are available and range from 10% to 30%, using various models to handle missing data.

The following programs and resources have been developed since 2010 to target health care professionals: The Registered Nurses' Association of Ontario Best Practice Champions for Smoke-Free Pregnancies Workshops, You Can Make it Happen, Brief Counselling for Tobacco Cessation: A Guide for Health Professionals, Women and Tobacco Info Pack: Gain A Better Understanding of How Smoking Affects Women's Health, and Reach 'n Teach. The main goal of these initiatives is to strengthen the capabilities of health professionals to provide cessation-based services to a diverse range of tobacco users. (Please see [The Jurisdictional Scan](#) for further details).

One other ongoing Ontario initiative that targets health care professionals is the Training Enhancement in Applied Cessation Counselling and Health Project (TEACH). TEACH is an Ontario-wide initiative, launched in 2006, to improve the capacity of health care professionals to provide intensive cessation counselling.<sup>9</sup> The project offers evidence-based core training courses to a variety of health care professionals (e.g., registered nurses, addiction counsellors, social workers, respiratory therapists and pharmacists). To date, TEACH has trained 4,536 health practitioners across Ontario. It also offers tailored courses for interventions with specific populations including patients with mental health, addictions or chronic disease, woman-centred approaches, and First Nations, Inuit and Métis populations.<sup>9</sup> The program has become a standard training method for primary-care and community-based centres that offer cessation services, such as, Family Health Teams, Community Health Centres, Addiction Agencies, and Aboriginal Health Access Centres.<sup>9</sup> Outcomes of the TEACH training are evident at six months and one year later. It should be noted that all Stop On the Road interventions are offered by TEACH-trained



practitioners.<sup>9</sup> A specialized TEACH is also offered to dentists in partnership with the Ontario Dental Association.<sup>9</sup>

In 2012, OTRU conducted a study on behalf of the MOHLTC to explore the experiences of dentists, dental hygienists and dental assistants in providing smoking cessation services to their patients within routine daily practice.<sup>79</sup> An online survey was distributed to 21,922 dental health professionals across the province using convenience sampling. The response rate was 9% (1,966 out of 21,922).<sup>79</sup> Main findings of the study indicate that 21% of online survey respondents had received formal training in smoking cessation and less than 50% of respondents provided any form of smoking cessation services to all or most of their patients who smoke.<sup>79</sup> The majority of respondents reported being only somewhat confident in their knowledge and skills to provide smoking cessation services, though many responded that they were enthusiastic to provide such services.<sup>79</sup> As the response rate for the survey was very low, the results may not be representative of the experiences of dentists, dental hygienists and dental assistants; results should be interpreted with caution. For a detailed overview of OTRU's findings refer to the *Provision of Smoking Cessation by Ontario Dental Health Professionals* report 2012.<sup>79</sup>

In a 2004 position paper, the Canadian Dental Hygienists Association indicated that dental hygienists play a key role in delivering consistent tobacco use cessation messaging as members of an interdisciplinary health professional team, and have a responsibility to provide tobacco cessation services as an integral part of oral health services.<sup>80</sup> Screening for tobacco use is currently on a voluntary basis for private oral health services.

### Evaluation Highlight

OTRU conducted an evaluation of the Ontario Pharmacy Smoking Cessation Program, highlighting reach and types of service usage. It was reported that there has been a steady increase in enrollment rates by Ontario Drug Benefit recipients since the initial start date. However, only a third of Ontario pharmacies have participated in the program, with 56% of patients receiving follow-up services. OTRU's evaluation found that 25,625 Ontario Drug Benefit patients received cessation medication or counselling in 20-15. Of these patients, 24,815 received medication and 3,704 received counselling. The majority consisted of individuals using Ministry of Community and Social Services programs (Ontario Disability Support Program or Ontario Works); 32% were age 65+.<sup>9</sup>

### Evidence

Eleven systematic reviews with meta-analyses,<sup>81-91</sup> one meta-analysis,<sup>92</sup> and six systematic reviews<sup>93-98</sup> were retrieved from the pre-appraised literature search. One review<sup>58</sup> was submitted by SFO-SAC. Fourteen reviews were appraised as Level I,<sup>83-95,97</sup> four as Level II<sup>81,82,96,98</sup> and one as Level III (West 2015).<sup>58</sup> Most studies took place in Europe and the U.S., some in Canada and Australia, and individual studies in Chile, Israel, Turkey, Japan and Korea.

### Evidence of Effectiveness

In **primary care** settings, a Cochrane systematic review found physician advice significantly increased quitting rate (RR: 1.66, 95% CI: 1.42-1.94) compared to no advice or usual care.<sup>86</sup> It was found that significantly higher quit rates resulted from greater intensity of physician advice (through greater time

commitment and additional materials, besides leaflets) compared to no advice (RR: 1.86, 95% CI: 1.60-2.15) or minimal control (e.g. brief single consultation with or without leaflet, plus up to one follow-up visit) (RR: 1.37, 95% CI: 1.20-1.56).<sup>86</sup> A systematic review and meta-analysis found adjunct counselling significantly increased abstinence rates (OR: 1.73, 95% CI: 1.48-2.01), as did multi-component interventions (e.g., cost-free NRT in addition to education and practice-based supports to physician/professional delivering intervention) (OR: 2.19, 95% CI: 1.7-2.8) compared to no intervention, self-help materials, or usual care.<sup>82</sup> Similar results were also seen in an older systematic review<sup>89</sup> and in interventions in which nurses delivered cessation advice.<sup>90</sup> Behavioural/counselling interventions, such as group counselling, 'buddy' interventions (where individual smokers pair up to offer mutual support while trying to quit), brief advice and face-to-face behavioural support showed promising results in increasing abstinence or quit rates (where reviews did not report relative risk or odds ratio with confidence intervals).<sup>58,93</sup> Printed self-help materials showed small (OR: 1.50, 95% CI: 1.1-2.1)<sup>82</sup> or non-significant effects on abstinence rates.<sup>58,82</sup>

A review of the outpatient **pre-operative** setting found that intense behavioural interventions (multiple contacts, initiated at least four weeks before surgery) showed a larger significant effect in both short-term (RR: 10.76, 95% CI: 4.55-25.46) and long-term follow-up (RR: 2.96, 95% CI: 1.57-5.55) compared to control group participants (who received standard care with little or no information about smoking cessation or harm of tobacco smoking).<sup>87</sup>

Two systematic reviews (one also a meta-analysis) that focused on cessation interventions delivered in **emergency department** settings found the majority of interventions, including a combination of self-help materials, motivational interviewing, referrals to cessation programs, additional phone calls, counselling and brief advice, compared to a control (e.g., self-help material, referral or brief advice alone) did not have significant effects on smoking abstinence with various follow-up periods ranging from one to 12 months post-enrollment.<sup>83,94</sup> For example, based on seven randomized control trials primarily on adults (one study was on adolescents) in mostly urban emergency departments, there was a significant increase in point prevalence tobacco abstinence at one month (RR: 1.47, 95% CI: 1.06-2.06) but not at 3, 6 or 12 months follow-up (RR 1.24, 95% CI: 0.93-1.65; RR: 1.13, 95% CI: 0.86-1.49; RR 1.25, 95% CI: 0.91-1.72).<sup>83</sup>

With respect to **dental care** settings, a Cochrane review reported that interventions such as self-help materials, counselling, pharmacotherapy, referral to other sources of support or any combination of these interventions had significant effects on increasing abstinence rates compared to usual care or less treatment intensive controls (OR: 2.38, 95% CI: 1.70-3.35).<sup>84</sup> An older systematic review and meta-analysis came to the same conclusions, with the same but fewer included studies.<sup>81</sup>

In **community pharmacy** settings, a meta-analysis reported that five pharmacist-led interventions, including some form of advice and counselling (one-on-one or within a group), significantly increased abstinence rates compared to the control group receiving standard or usual care.<sup>85</sup> This was the case for short-term (<12 weeks) (RR: 2.48, 95% CI: 1.15-5.31), mid-term (12-24 weeks) (RR: 2.72, 95% CI: 1.38-5.38), and long-term (>24 weeks) (RR: 2.40, 95% CI: 1.37-4.23) abstinence.<sup>85</sup> There was moderate heterogeneity for overall and long-term follow-up and significantly high heterogeneity for short-term ( $I^2$

= 87.6%) and mid-term follow-up ( $I^2 = 77.7\%$ ); therefore, results must be interpreted with caution because the moderate/high heterogeneity indicates there is a substantial amount of variability between the studies analyzed in this paper.<sup>85</sup>

Furthermore, a systematic review with 10 included studies (three of which were included in Saba et al. 2014) also analyzed pharmacist-led interventions.<sup>95</sup> Results showed that four out of six studies on non-pharmacological interventions (i.e., behavioural counselling or support) delivered by pharmacy personnel showed statistically significant benefits of the intervention compared to the control group (e.g., adjusted OR: 2.42, 95%CI: 1.90-3.08).<sup>95</sup> Results also suggested that multiple sessions were better than only one session. Two studies on pharmacological interventions (using nicotine patches) found mixed results; one study reported intervention benefits and the other two reported no intervention benefit at six months.<sup>95</sup> Similar results were also seen in three studies on interventions with a non-pharmacological and a pharmacological component.

### **Intervention Characteristics/Implementation Considerations**

There were a few reviews that focused on interventions that strengthen the capacity of health care professionals (e.g., primary care physicians, nurses, dentists, psychologists or pharmacists) to provide cessation services. Health care professional capacity-building interventions such as training in smoking cessation care, financial incentives (e.g., I pay for good performance and practice, fee-per-service, salary capitation), and the use of electronic medical records (EMR) as a prompt for providing cessation care, are effective on provider-level outcomes (i.e., provision of smoking cessation interventions and referrals).<sup>92,97,98</sup> No significant effect was found for provider-level outcomes related to providing NRT.<sup>92</sup> Health care professional training was also effective on client-level outcomes such as significantly increasing the point prevalence of smoking in the intervention, compared to control (OR: 1.36, 95% CI: 1.20-1.55) and continuous abstinence (OR: 1.60, 95% CI: 1.26-2.03);<sup>92</sup> with the exception of financial incentive interventions, which did not have a significant effect on client-level outcomes.<sup>91,96</sup>

In contrast, the Papadakis et al. (2010) review found that practice-level interventions (including screening for smoking status and readiness to quit, checklists, electronic prompts, educational outreach provided to physicians and increased duration of physician visit) did not show a significant effect on smoking abstinence at six or 12 months.<sup>82</sup> However, multi-component interventions that combined education and practice-based supports were shown to increase practitioners' delivery of smoking cessation interventions, thereby significantly increasing smoking abstinence at six or 12 months (OR: 2.19, 95% CI: 1.71-2.79).<sup>82</sup>

### **Specific Populations/Equity Considerations**

In the U.K., it was found that younger smokers, females, pregnant smokers and smokers living in deprived areas, who receive National Health Service counselling in primary care, appear to have lower short-term quit rates than other groups.<sup>93</sup> A systematic review of primary-care interventions for children and adolescents found that neither behavioural or bupropion cessation interventions improved cessation rates.<sup>88</sup>

## Intervention Summary

### **Evidence Summary - Other Healthcare Setting Cessation Interventions - Well supported**

The body of evidence regarding the effectiveness of interventions in primary care and other health care settings for smoking cessation included ten systematic reviews with meta-analysis, three systematic reviews and one review (11 appraised as Level I, two as Level II, and one as Level III). Interventions (mostly behavioural support/counselling of varying intensities, with or without pharmacotherapy) were overall effective at increasing smoking cessation and abstinence in primary care, outpatient pre-operative, dental care and pharmacy, but not in the emergency department setting. Interventions in these healthcare settings can vary in terms of intervention type and intensity, health care provider (i.e., nurses, pharmacists, primary care physicians and dentists), and setting.

### **SFO-SAC 2016 Scientific Consensus Statement - High (Intensify)**

There are programs in Ontario that support other health care setting cessation interventions to provide smoking cessation services. Examples include the TEACH Project and the Registered Nurses' Association of Ontario: Nursing Best Practice Smoking Cessation Initiative. There are also Ontario initiatives that aim to facilitate the delivery of cessation services, including the OMSC, Moving On to Being Free™, and Smoking Treatment for Ontario Patients program (STOP). Based on the summary of evidence, smoking cessation interventions were effective at increasing smoking cessation in all locations (except in emergency departments), regardless of the type of health professional who delivered the intervention. Interventions in other health care settings could reach a number of smokers in Ontario. It is important to ensure that all types of primary health care teams (i.e., solo primary care physicians and physician groups) and private practices (i.e., dentistry) receive support to deliver smoking cessation interventions.

The scientific consensus regarding the potential contribution for Ontario is: High (intensify).

### **Key Message**

Interventions in health care settings other than hospitals, such as primary care and outpatient pre-operative clinics, dental practices and pharmacies, but not in emergency departments, are effective at increasing smoking cessation. There is an opportunity in Ontario for further development of tobacco control initiatives in these settings.